



# A Prevention Prescription for Improving Health and Health Care in America

## *Executive Summary*

May 2015



BIPARTISAN POLICY CENTER

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## **ACKNOWLEDGMENTS**

BPC would like to thank the Laura and John Arnold Foundation for their generous support.

This paper was produced by the Prevention Task Force members, with input from our distinguished Senior Advisors and support from BPC staff. BPC would like to thank Janet Collins, Darshak Sanghavi, Joann Donnellan, Steve Gortmaker, Debbie Chang, David Flemming, and Samuel Ross for their input and Katherine Hayes, Janet Marchibroda, Ashley Ridlon, and Martha Presley for their feedback, support, and direction.

## **DISCLAIMER**

This report is the product of the BPC Prevention Task Force with participants of diverse expertise and affiliations, addressing complex topics, and it is inevitable that arriving at a consensus document in these circumstances entailed compromises. Ultimately, however, this group reached consensus on these recommendations as a package of priority recommendations.

The findings and recommendations expressed herein are solely those of the task force and do not necessarily represent the views or opinions of the Bipartisan Policy Center, its founders, or its Board of Directors.

# Executive Summary



## *The BPC Prevention Task Force*

In 2014, the Bipartisan Policy Center (BPC) convened a Prevention Task Force to focus on opportunities for investing in prevention as a way to improve health outcomes and reduce health care costs. The task force included a diverse group of experts to review the evidence on prevention and to frame a strategy for better integrating prevention in the nation's approach to health and health care.

Fundamentally, there is growing recognition that prevention—delivered correctly—holds vast potential to improve health at the individual and population level, while also reducing national spending on health care. Better health is an important goal in and of

itself, with benefits—in productivity, longevity, wellbeing, and quality of life—that extend to all levels of society, from individuals and families to communities, businesses, and government. Of course, not all prevention strategies will be effective, and not all health improvements will result in cost savings. But prevention clearly has a role to play in advancing several widely shared objectives of current health care reform efforts.

Interest in tapping that potential has gained momentum recently, spurred by major policy developments, such as the passage of the Affordable Care Act, and by growing awareness of the linkages that exist among high rates of obesity and chronic disease, rising health care costs, and poor health outcomes for many Americans.

The critical questions now center on how to pursue greater integration and overcome complex challenges—such as realigning incentives within the health care system to improving coordination, bridging the gap between clinic and community, and finding ways to evaluate interventions and measure impacts that are inherently complex and long-term.

### *A Two-Part Framework for Progress on Prevention*

The task force proposes a two-part framework to address these challenges and to begin accelerating investment in prevention-oriented strategies. This framework recognizes that preventable chronic conditions are widespread and costly, that much of the work of effective prevention strategies must occur outside the doctor’s office, that the current understanding of what approaches are effective in non-clinical settings is limited, that problems as complex as obesity and chronic disease will require multiple interventions to show impact, that accomplishing a shift toward disease prevention and wellness will require new kinds of integrated entities and financing mechanisms, and that it will be important to test the effectiveness of these new strategies and entities.

### *Recommendations*

The task force’s first set of recommendations focus on building the evidence base for prevention. To capture and translate the best available information on effective interventions and to develop appropriate metrics for evaluating progress, we recommend:

1) **The Centers for Disease Control and Prevention (CDC)** and the National Institutes of Health (NIH) should include a requirement for economic analysis (or cost-effectiveness analysis) in clinical and public health funding opportunity announcements (FOAs) to help build cost-related evidence from public health interventions. The same requirements should be applied to clinical interventions as well.

2) **The Centers for Medicare and Medicaid Services (CMS)** should include a requirement for economic analyses (or cost-effectiveness analysis) in FOAs to help build cost-related evidence from public health interventions.

3) **Public health journals** should give priority to, and thereby encourage, economic analysis in studies of prevention strategies.

4) **Public and private funders** should encourage and fund studies of the health and economic effects of proven and emerging population-level interventions and prevention strategies. In particular, funders should take advantage of “real world” natural experiments (affecting 10,000+ individuals) to investigate the population-level health and fiscal effects of integrated community prevention and clinical care interventions.

5) **Congress should assure adequate funding** for the CDC Community Preventive Services Task Force (CPSTF) with the aim of expanding the number of community-level public health interventions that can be reviewed for inclusion in, and wide dissemination through, the CDC’s Guide to Community Preventive Services and other evidence-based sources. These reviews identify interventions that are and are not ready for wide implementation, as well as the research needed to address key evidence gaps.

6) **Congressional budget committees** should direct the Congressional Budget Office (CBO) to use “present discount accounting” to bring long-term savings from prevention “up” in time and to align better with CBO’s current 10-year scoring window; these changes will help ensure that CBO is accounting for benefits that might be seen 20–25 years out.

The second part of the task force’s framework focuses on near-term opportunities to embed prevention in broader health care delivery system reforms. We recommend:

- 1) **CMS should integrate at least two** (and preferably more) population health care quality measures into the next iteration of accountable care organization (ACOs) to drive system change that supports health by reducing the prevalence of risk factors and the incidence of disease.
- 2) **CMS, through its Center for Medicare and Medicaid Innovation (CMMI)** should invest in a robust demonstration of an accountable health community (AHC) model, which could establish a concrete framework for improving population health while leveraging the existing delivery-system infrastructure.
- 3) **CMS should invest in evaluating AHC models** that focus on establishing funding mechanisms that can be both scaled and sustained over time. Investments in AHCs should include specific provisions (and funding) for (a) identifying the full suite of relevant stakeholders (including stakeholders whose downstream budgets might benefit from effective upstream prevention), (b) identifying shared outcomes as a basis for pooling financial resources, (c) providing an integrator, (d) using innovative mechanisms to address the “wrong pocket” problem, (i.e., where investments and savings may be made by/accrue to different entities), and (e) using technology to share data and support communication.
- 4) **CMS should support efforts** to synthesize and translate lessons learned from CMMI and other programs, including investing in infrastructure to help spread and scale what works and sponsoring analyses to predict likely health and economic impacts in defined populations and jurisdictions. In addition, CMS should consider including requirements for translating and disseminating findings and results in the RFP process.

- 5) **Communities, public health officials, and hospitals** should collectively explore ways to improve Community Health Needs Assessments and better use these assessments as a tool for aligning goals and implementation plans. At the same time, communities, public health officials, and hospitals should engage with other stakeholders to identify existing organizations at the state, regional, or local level that could function as integrators, potentially with additional support from national-level organizations (e.g., the National Association of Counties, the National Association of County and City Health Officials, the Centers for Disease Control and Prevention, and the American Heart Association).

## **Conclusion**

The work of the Prevention Task Force is motivated by a core premise: that engaging a broader array of community-level drivers and resources for disease prevention and health promotion can help more Americans enjoy longer, healthier, and more productive lives while also reducing overall health care spending. Recognizing that the U.S. health care system is still in the early phases of a transformational shift, our goal has been to identify challenges, highlight near-term opportunities for progress, and begin bringing together the diverse organizations and institutions—both within and outside the traditional health care sector—whose resources, expertise, and commitment are needed to deliver on the promise of achieving better health, better health care, and lower health costs through prevention.

As Americans, we spend an enormous amount of health care dollars treating largely preventable chronic conditions. Prevention can reduce demand on the health care system. To access the value of prevention, we must shift our focus to keeping people healthy. We also need a payment system that incentivizes the types of upfront investments that reduce downstream treatment costs.

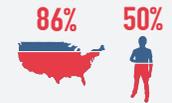
## FACING FACTS



2x

### Americans Spend Twice as Much on Health Care as Citizens of Other Developed Countries

Yet we have shorter life expectancies, and higher rates of infant mortality and diabetes.



86%

50%

### Chronic Disease Dominates Health Care Costs

Chronic diseases account for 86 percent of U.S. health care costs and affect 50 percent of the adult population.



### Social, Environmental, and Economic Factors

Where people live, work, learn, and play has a greater influence on their health than what goes on in the doctor's office, yet the health care system bears the brunt of these problems when they ultimately lead to poor health outcomes.



### Structural Barriers

The health care system has few structural or financial mechanisms for connecting effectively with the broader community beyond the clinic walls or leveraging resources to maximize health outcomes.

## THE CHALLENGES



The emerging evidence base around prevention is fragmented and lacks cost metrics, which are very important to policy makers.



Current fee-for-service payment models do not reward health care systems for working upstream to prevent illness.



There are opportunities through current Affordable Care Act provisions to better align incentives.

## ✓ Recommendations

1

### Continue building the evidence base on the value of prevention.

Federal agencies, philanthropies, public health research journals, and Congress all have roles to play in supporting the development of robust economic analysis of prevention interventions and the promotion of strategies that are proven to improve health and cut costs.

2

### Make prevention a key part of health care delivery system reform.

The Centers for Medicare and Medicaid Services has several ways to advance this, including population-based quality measures and promising models such as the Accountable Health Community model that could be tested on a broad scale through its Center for Medicare and Medicaid Innovation. On the ground, stakeholders can better capitalize on new opportunities such as the Community Health Needs Assessment to collaborate on common goals in their communities.



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